Health Regulation & Licensing Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HFD02-0001	A. BUILDING: _____ B. WING _____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENT	2131 O STREET NW WASHINGTON, DC 20037

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L 000	Initial Comments An unannounced Recertification Survey was conducted at this facility from October 30, 2023 to November 14, 2023. Survey activities consisted of observations, record reviews, and resident and staff interviews. The facility's census on the first day of the survey was 167 and the survey sample included 47 residents. The following Complaints were investigated: DC~11545, DC~11871, DC~12392, DC~12341, DC12130, and DC ~11948. The following Facility Reported Incidents were investigated: DC~11464 DC~11116 DC~11992 DC~11144 DC~11357 DC~11434 DC~11664 DC~11597 DC~11456 DC~11326 DC~11081 DC~11845 DC~11306 DC~11789 DC~11647 DC~12273 DC~11180 DC~11505 After analysis of the findings, it was determined that the facility was not in compliance with the requirements of 22B District of Columbia Municipal Regulations (DCMR) Chapter 32	L 000		

Health Regulation & Licensing Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald Cheli	Administrator	12/8/2023

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L 000	Continued From page 1 requirements for Long Term Care. Citations are being cited for: DC~12341, DC~11326, DC~12130, DC11081, DC~11144, DC~11545, DC~11434, DC~11505, and DC~11597. The following is a directory of abbreviations and/or acronyms that may be utilized in the report: AMS - Altered Mental Status ARD - Assessment Reference Date AV- Arteriovenous BID - Twice- a-day B/P - Blood Pressure cm - Centimeters CFR- Code of Federal Regulations CMS - Centers for Medicare and Medicaid Services CNA- Certified Nurse Aide CRF - Community Residential Facility CRNP- Certified Registered Nurse Practitioner D.C. - District of Columbia DCMR- District of Columbia Municipal Regulations D/C - Discontinue Dl - Deciliter DMH - Department of Mental Health DOH - Department of Health DON - Director of Nursing ED - Emergency Department EKG - 12 lead Electrocardiogram EMS - Emergency Medical Services (911) ER - Emergency Room F - Fahrenheit FR. - French FRI - Facility reported incident G-tube - Gastrostomy tube HR - Human Resources	L 000		

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L 000	Continued From page 2	L 000		

Hrs - Hours
HS - hour of sleep
HSC - Health Service Center
HVAC - Heating ventilation/Air conditioning
ID - Intellectual disability
IDT - Interdisciplinary team
IPCP - Infection Prevention and Control Program
LPN - Licensed Practical Nurse
L - Liter
Lbs - Pounds (unit of mass)
MAR - Medication Administration Record
MD - Medical Doctor
MDS - Minimum Data Set
Mg - milligrams (metric system unit of mass)
M - Minute
ML - milliliters (metric system measure of volume)
Mg/dl - milligrams per deciliter
Mm/Hg - millimeters of mercury
MN - midnight
N/C - nasal cannula
Neuro - Neurological
NFPA - National Fire Protection Association
NP - Nurse Practitioner
O2 - Oxygen
PA - Physician's Assistant
PASRR - Preadmission screen and Resident Review
Peg tube - Percutaneous Endoscopic Gastrostomy
PO - by mouth
POA - Power of Attorney
POS - physician's order sheet
Prn - As needed
Pt - Patient
Q - Every
RD - Registered Dietitian
RN - Registered Nurse
ROM - Range of Motion
RP R/P - Responsible party
SBAR - Situation, Background, Assessment,

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L 000	Continued From page 3 Recommendation SCC - Special Care Center Sol - Solution SW - Social Worker TAR - Treatment Administration Record Ug - Microgram	L 000		
L 003	3201.2 Nursing Facilities The Administrator shall be: (a) Licensed or otherwise approved as a nursing home administrator in the District of Columbia; and (b) Certified annually by a licensed physician as having no physical or mental disabilities that would interfere with carrying out the Administrator's responsibilities. This Statute is not met as evidenced by: Based on record reviews and staff interviews for one (1) of 47 sampled residents, facility staff failed to ensure that each medical record was maintained, completed and preserved. Resident #379 The findings included: Facility staff failed to accurately code Resident #379's Quarterly Minimum Data Set (MDS) assessments to accurately reflect the resident's history of falls and failed to accurately code Resident #174's Admission MDS to reflect the resident's surgical wound. Resident #379 was admitted to the facility on 12/01/22 with diagnoses that included: Cognitive Communication Deficit, Muscle Weakness, Unspecified, Severe	L 003	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 379 and 174 suffered no negative outcomes from failure of MDS to accurately code the residents quarterly MDS assessment. The MDS for these residents were corrected on 11/3. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by MDS department for all residents that had a surgical wound and/or fall within the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Regional Director of MDS completed an in-service all staff and leadership on the Policy and procedures regarding how to accurately code falls and surgical wounds for the resident's MDS assessments. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION**	12/8/2023

			An audit will be done by the Regional MDS Director to ensure the facility implements its policy on MDS assessments for accurate coding for falls and surgical wounds. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 003	Continued From page 4 Protein-Calorie Malnutrition, Adult Failure to Thrive, History of Falls, Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety. A review of Resident #379's medical record revealed the following: A physician's order dated 12/01/2 at 11:0 PM documented: "Precautions: Fall every shift." A care plan initiated on 12/02/22 documented: "Focus: [Resident #379] has Fall Prevention in place ... Goal: [Resident Name] will have reduced incidents of falls through the next review period x 90..." An Admission Minimum Data Set (MDS) assessment dated 12/05/22 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "08," indicating the Resident had moderately impaired cognition and had a history of falls that included a fall within 2-6 months of the admission assessment. A Post Fall Assessment done on 12/26/22 at 1:15 PM documented: "Score 10.0 Moderate Risk for recent fall." SBAR Physician/NP (Nurse Practitioner)/PA (Physician Assistant) Communication Tool on 12/26/22 at 1:52 PM documented: " ... "Reason: Fall ...Additional Comments: " ...Writer was alerted by OT (Occupational Therapist) that patient was on the floor. Observed [the] patient sitting on the floor leaning against the wall outside her room. When asked what happen(ed)? Pt (patient) stated, "I was going across the hall to my neighbor, and I fell." Pt was assessed head to toe, UL (upper and lower) ext (extremity) ROM (range of motion) within limits. Denies pain or	L 003		

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L 003	Continued From page 5 discomfort. Pt (patient) was assisted up by [the] writer and therapist using [a] gait belt and rolling walker." A care plan initiated on 12/26/22 documented: "Focus: [Resident# 374] had an actual fall with no injury due to unsteady gait..... " The care plan was revised on 01/13/23 and documented: "Focus: [Resident] was observed on the floor on 01/13/23 with an abrasion 0.3 x 0.3 cm x 0 at the back of her head ... " SBAR Physician/NP/PA Communication Tool on 01/13/23 at 4:50 PM documented: "... Reason: Fall with an apparent head injury..... Additional Comments: Resident was observed on the floor on her back .. Upon assessment, a minor blood was noted at the back of her head, the area was cleaned with normal saline, an ice pack was applied to the area, no bleeding. Pressure dressing was applied to the site. Resident is alert. Resident was asked if she hurts anywhere, she said no .... Resident was assisted back to the bed by three nursing staff. [Physician's Name] was notified, ... gave an order to send Resident to the nearest ER (Emergency Room) for evaluation and treatment ... " A Department of Health Complaint /Incident Report submitted on 01/13/23 at 8:18 PM that documented: "Writer was informed that Resident was observed on the floor on her back at 4:50 PM. A nursing staff called the charge nurse to assess this Resident. Upon assessment, minor blood was noted at the back of her head ...area was cleaned with normal saline, ice pack was applied to the area ... Pressure dressing was applied to the site. Resident is alert, verbally responsive, but she could not recall how she got on the floor. Resident was asked if she hurts	L 003		

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L 003	Continued From page 6 anywhere, she said no. She was able to move her extremities. The bed was on the lowest Position and the call bell was in the bed. Resident was assisted back to the bed by three nursing staff... [Name of Physician] was notified, she gave an order to send Resident to the nearest Emergency Room (ER) for evaluation and treatment ..." A review of Resident #379's medical record revealed that the Resident had two falls; one fall with no injury on 12/26/22 and another fall with injury on 01/13/23. A Quarterly MDS assessment dated 01/27/23 documented that Resident #379 had only one fall (with a minor injury) since the Resident's last assessment on 12/05/22, or since the resident's admission on 12/01/22. During a face-to-face interview on 11/06/23 at 11:30 AM, Employee #15 (MDS Coordinator), acknowledged that the fall with no injury (on 12/26/222) was missed, and she stated that she would correct the resident's MDS assessment to include the Resident's fall. [Cross over tag F641]	L 003		
L 015	3203.5 Nursing Facilities Each facility shall maintain the following administrative records: (a) Payroll records; (b) Reports of fire inspections; (c) Compliance reports required to be maintained pursuant to the 1996	L 015	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. Residents 103, 331, and 332 suffered no negative outcomes from the deficient practice. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED**	12/8/2023

			All residents have the potential to be affected by this deficient practice. An audit was done by the ADON for all incidents and accidents that occurred in the last 90 days to ensure that the Abuse protocol was followed with appropriate investigating, reporting and corrective actions. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding suspending staff, pending investigations. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, Falls, are discussed during the Risk meetings to ensure the facility implements its policy on investigating incidents of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Negative findings, if any, will be corrected upon discovery. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on abuse and reportable incidents. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 015	Continued From page 7 BOCA National Building Code, construction and permit regulations; (d) Reports of inspections of the fire alarm system and fire drills; (e) Reports of elevator inspections; (f)Disaster plan and procedures; (g) Certification of flame spread ratings of carpets, curtains and wall coverings; (h) Each contract for professional and facility services; (i) Radiation survey reports of x-ray equipment, if applicable; (j) Summaries and analyses of each incident involving residents, staff and visitors; and (k) Policies and procedures governing the operation of the facility. This Statute is not met as evidenced by: Based on record review and staff interviews, for one (1) of of 47 sampled residents, facility staff failed to have a summary and analyse of an allegation of abuse involving Resident #103 and Employee #13 that documented the corrective actions taken/implemented to protect and prevent further potential abuse of the resident. Resident #103. The findings included: Review of the facility's "Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating" policy documented:	L 015		

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L 015	Continued From page 8 - The Administrator ensures that the resident and the person(s) reporting the suspected violation are protected from retaliation or reprisal by the alleged perpetrator, or by anyone associated with the facility. - If the investigation reveals that the allegation(s) of abuse are unfounded, the employee(s) may be reinstated to his/her/their former position and will be paid in full for the duration of the suspension. - The employee will obtain education for the incident prior to returning to work and will not be allowed to work with the suspected victim to prevent retaliation. - Corrective actions may include a full review of the incident(s) by the QAPI committee. 1. Facility staff failed to to have documented evidence that they took corrective actions to protect and prevent further potential abuse of Resident #10 for six months after an alleged incident. Resident #103 was admitted to the facility on 01/25/20 with diagnoses that included: Schizophrenia and Depressive Disorder. Review of Resident #103's medical record revealed the following: A care plan focus area last revised in March 2022 documented, "[Resident #103] wishes to smoke at the facility and is assessed as a Safe Smoker" A Quarterly Minimum Data Set (MDS) assessment dated 09/05/22 showed that facility staff coded: clear speech; understood others and able to make self understood; and a Brief Interview for Mental Status (BIMS) Summary Score of 10, indicating moderate impaired cognition.	L 015		

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L 015	Continued From page 9 A schedule for calendar for September 2022 documented that on 09/29/23 from 9:30 AM - 6:00 PM, Employee #13/alleged perpetrator was the assigned to the courtyard/smoking patio. A Situation Background Assessment Request (SBAR) Communication Tool dated 09/29/22 at 11:00 AM documented: - Situation - At 10:30AM Resident alleged smoke aide put his hands on his left shoulder, at the smoking area. - Resident denies pain; head to toe assessment shows no bruises or any skin issue. Staff suspended pending investigation. - Medical Doctor and representative made aware. A care plan focus area initiated on 10/04/22 documented, - [Resident #103] is at risk of feelings emptiness, anxiety, uneasiness, characterized by; ineffective coping, related to restricted physical activity (smoking) AEB (as evidenced by) reported that assigned smoke aide did not maintain his physical distance (finger on him shoulder) for redirection in the designated smoking area. Review of Employee #13's human resources (HR) file on 11/01/23 at approximately 9:00 AM, showed a "Disciplinary Action Form" dated 09/29/22 that documented: - It was alleged [Employee #13 tapped [Resident #103] on the shoulder with his finger and asked him to return inside. - Corrective Action Taken - [Employee #13] will be suspended pending investigation. - Employee #13 received abuse training and education on 10/05/22 and returned to work on 10/06/22.	L 015		

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L 015	Continued From page 10 It should be noted that there was no documented evidence in Employee #13's HR file to show that the employee was no longer working as a Smoke Aide upon returning from suspension. Review of the facility's investigation documents on 11/01/23 at 9:30 AM showed a document dated 03/21/23 that documented: - Per the facility policy, you [Employee #13] are not to come in contact with this resident [Resident #103] at any time. - This means you will not provide direct care or services to this resident, or enter this resident's room for any reason (not even to provide care or services to their roommate. A conference was conducted on 11/01/23 at 10:30 AM with Employee #1 (Administrator), Employee #2 (Director of Nursing/DON), Employee #3 (Assistant Director of Nursing/ADON), and Employee #14 (Human Resources Manager/HRM). During the conference, the employees were asked to explain why did take until 03/21/23, approximately six months after the alleged incident, for the facility administration to have documented evidence of the corrective actions that were taken to protect and prevent further potential abuse of Resident #103 from Employee #13. Employee #2 sated, "After the investigation and suspension, [Employee #13] was removed from that position (Smoke Aide) and worked as restorative aide." When asked to show/provide documented evidence of Employee #13's position change after allegation, Employee #14 reviewed Employee #13's HR file and acknowledged that there was no such documentation. On 11/02/23 at 12:00 PM, Employee #1 and Employee #2 came to the State Surveyor with	L 015		

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L 015	Continued From page 11 documents and Employee #1 stated, "We called the previous Administrator who was here at the time of this incident (09/29/22) and she directed us looked through some folders and we found these additional documents." The additional documents showed: - A "Personnel Action Notice" dated 03/21/23 with Employee #13's name; "Job/Department Change"; "Current Job/Department: Smoking Aide"; "New Job/Department CNA (Certified Nurse Aide)/Restorative". Employee #1 stated, "The board held a meeting in March [2023] and reviewed all incidents that involved allegations of abuse. For this particular case, they felt it was warranted to take the steps of removing [Employee #13] from the position of a smoke aide to restorative aide out of abundance of caution." When asked prior to this personnel action, where was the employee working, Employee #2 stated, "[Employee #13] was working as the Smoke Aide and there were cameras out there that were being monitored at all times by the front desk staff." The evidence showed that from 10/06/22 to 03/21/23, approximately six months, facility staff failed to have documented evidence that they took any corrective actions to protect and prevent further potential abuse of Resident #103 by Employee #13. During a face-to-face interview on 11/02/23 at 12:08 PM, Employees #1 and #2 acknowledged the finding.	L 015		
L 051	3210.4 Nursing Facilities A charge nurse shall be responsible for the following:	L 051	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #25 was assessed by nursing on 11/6 and suffered no negative outcomes	12/8/2023

			from failure to update the care plan for the refusal of palm guards. The Physician was made aware on 11/6 and orders were to continue to encourage resident to wear splints. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for all residents that have splint orders over the last 90 days and ensure they are accurately following the plan of care. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding updating care plans when new devices are introduced into resident's plan of care, or refusals are documented and ensuring the plan of care is followed. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on updating care plans when refusal for splint is documented. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 051	Continued From page 12 (a) Making daily resident visits to assess physical and emotional status and implementing any required nursing intervention; (b) Reviewing medication records for completeness, accuracy in the transcription of physician orders, and adherences to stop-order policies; (c) Reviewing residents' plans of care for appropriate goals and approaches, and revising them as needed; (d) Delegating responsibility to the nursing staff for direct resident nursing care of specific residents; (e) Supervising and evaluating each nursing employee on the unit; and (f) Keeping the Director of Nursing Services or his or her designee informed about the status of residents. This Statute is not met as evidenced by: Based on observations, record review and staff interviews for one (1) of 47 sampled residents, facility staff failed to ensure that a charge nurse reviewed a resident's plan of cae fora ppropriteness, goals, and approaches, and revised them as needed. Resident #25 The findings included: Resident #25 was admitted to the facility on 08/21/08 with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia. A review of Resident #25's medical record	L 051		

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	HFD02-0001	A. BUILDING: _____ B. WING _____	C 11/14/2023

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L 051	Continued From page 13 revealed the following: A Quarterly MDS dated 10/20/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "06," indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care. A physician's order dated 12/04/19 read: "Carrot palms to prevent further tightness on at 10:00 AM and off at 12:00 PM." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for skin integrity impairment related to immobility, incontinence ...Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of redness or skin breakdown ... Interventions: Apply pressure relief cushions and devices per order." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity ...Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) ...Interventions: ...splint application as recommended to right and left ext (extremity) ..." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands ...Goal: [Resident #25] will not have an increase of contracture by the next review in 90 days (initiated 06/14/16) ...Interventions: ...Apply carrot	L 051		

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L 051	Continued From page 14 palm guards as ordered ..." A physician's order dated 08/01/23 read: "Splinting order: Resident to wear bilateral palmer guard for 6 hours as tolerated to maintain skin integrity." During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room. During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand. Based on three observations and a review of Resident #25's comprehensive care plan, the evidence showed that facility staff failed to implement the Resident's use of bilateral palm guards. In addition, the Resident's refusal for treatment (i.e. Resident #25's refusal to keep palmar guards on hands) was not included as part of the resident's comprehensive care plan. During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), when asked about the Resident's use of palm guards, stated that the resident takes them off and throws them down on the floor. When asked if she or any of the other facility staff made the physician aware that the resident was	L 051		

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L 051	Continued From page 15 removing the palm guards, she stated that she had not, but would do so. The Employee then acknowledged that the Resident's refusal to keep the bilateral palm guards on should have been included as a focus of the resident's comprehensive care plan. [Cross-over tag F656]	L 051		
L 052	3211.1 Nursing Facilities Sufficient nursing time shall be given to each resident to ensure that the resident receives the following: (a) Treatment, medications, diet and nutritional supplements and fluids as prescribed, and rehabilitative nursing care as needed; (b) Proper care to minimize pressure ulcers and contractures and to promote the healing of ulcers: (c) Assistants in daily personal grooming so that the resident is comfortable, clean, and neat as evidenced by freedom from body odor, cleaned and trimmed nails, and clean, neat and well-groomed hair; (d) Protection from accident, injury, and infection; (e) Encouragement, assistance, and training in self-care and group activities; (f) Encouragement and assistance to: (1)Get out of the bed and dress or be dressed in his or her own clothing; and shoes or slippers, which shall be clean and in good repair;	L 052	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident #331 no longer resides at the facility. This deficiency cannot be retroactively corrected. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for residents that need assistance while toileting that they were assisted appropriately with no falls reported. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding ADL coding and ADL execution. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION**	12/8/2023

			An audit will be done by the Unit Managers to ensure the facility implements its policy on proper ADL assistance. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 052	Continued From page 16 (2) Use the dining room if he or she is able; and (3) Participate in meaningful social and recreational activities; with eating; (g) Prompt, unhurried assistance if he or she requires or request help with eating; (h) Prescribed adaptive self-help devices to assist him or her in eating independently; (i) Assistance, if needed, with daily hygiene, including oral acre; and j)Prompt response to an activated call bell or call for help. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 47 sampled residents the facility staff failed to adequately supervise Resident #331, while toileting as required by the residents Minimum Data Set (MDS) assessment which staff coded as requiring supervision and a one person staff assist with toileting. Resident 331. The Findings Included: Resident #331 was admitted to the facility on 01/05/23, with multiple diagnoses that included the following: Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit. A review of a complaint intake #DC00011545, that was submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out	L 052		

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L 052	Continued From page 17 nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..." A review of the facility's policy titled "Fall and Fall Management" documents " ...If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant ...Staff will monitor if interventions have been successful in preventing falling ...If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions ..." Review of Resident #331's medical record revealed the following: [Baseline Care Plan] dated 01/06/23, documents " ...Toilet use: support provided One-person physical assist ..." Review of an Admission Minimum Data Set assessment (MDS) dated 01/11/23, showed that the facility staff coded Resident #331 as having a Brief Interview for Mental status (BIMS) summary score of "14" which indicates intact cognition. The facility staff coded that the resident required supervision and one-person physical assist with toileting. [Nursing Progress Note] 01/11/23 at 2:00 AM, documents " ...At approximately 11:15 pm, a Night shift Staff answered a call bell light in Room 115 B, the Resident in Room 115 A was on the floor. She called another Staff to assist her with	L 052		

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L 052	Continued From page 18 the Resident. Writer was called to assist and assess the Resident. She was on the floor in a sitting Position on her buttocks and leaning on the bed. Resident said that she was going to the bathroom, urinated on the floor and missed her step and sledded on the floor. Pain assessment was done, she denied Pain, Neurological assessment was done, she is alert, oriented, no injury noted, she can move all her extremities, she did not verbalize any Pain or discomfort. Three Staff assisted her to her bed, call bell was already within reach. She was encouraged to call for assistance any time she needs help ..." [Post Fall Huddle] 01/11/23 at 1:12 AM, " ...Post-Fall Huddle Recommendations /New Intervention to prevent another fall (what could have been done differently-Encourage resident to use call bell and call for assistance ..." [Nursing Progress Note] 01/20/2023 at 9:52 AM, documents " ...around 5:40 am, Resident was taken to the bathroom and placed on the commode, and was told to pull the call light when she is done, the CNA (Certified Nurse Aide) was cleaning Resident's room when she heard her call for help, on getting inside the bathroom, Resident was observed sitting on the bathroom floor, As per Resident, she said she fell on her back, but denied hitting her head on the floor, Head to toe assessment done, no injury noted, ROM (Range of Motion) tolerated and within Resident's baseline, ..." [Post Fall Huddle] 01/20/23 at 6:57 AM, " ... Description of Fall- Resident was getting up from commode without calling for help ...Post- Fall Huddle Recommendations /New Intervention to prevent another fall what could have been done differently- Re educated to use call light ..."	L 052		

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L 052	Continued From page 19 [Release of Responsibility for Discharge] was signed by Resident #331 on 01/20/23 at 7:30PM. Review of the medical record lacked documented evidence that the facility staff provided supervision while toileting Resident #331. During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that supervision with toileting means that the staff should be in the bathroom with the resident and acknowledged the findings.	L 052		
L 065	3213.2 Nursing Facilities Each nursing employee shall provide restorative nursing in his or her daily care of residents, which shall include the following: (a) Maintaining good body alignment and proper positioning of bedridden residents; (b) Encouraging and assisting bedridden residents or those residents that are confined to a chair to change position at least every two (2) hours or more often as the resident's condition warrants, day and night, to stimulate circulation; prevent bed sores, pressure ulcers and deformities; and to promote the healing of pressure ulcers; (c) Encouraging residents to be active and out of bed for reasonable periods of time, except when contraindicated by physician's orders; (d) Encouraging residents to be independent in activities of daily living by teaching and explaining the importance of self-care, ensuring and assisting with transfer and ambulating activities, by allowing sufficient time for task completion by	L 065	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident 25 suffered no negative outcomes from failure to apply palm guards and notify physician. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for all residents that have refused splint orders over the last 8 days to ensure that the Physician is notified. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee in-serviced all Restorative Aides and nursing leadership	12/8/2023

			on the Policy and procedures regarding carrying out Physicians orders for restorative care and contacting them when any changes or refusals occur. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on physician orders and contacting physicians for refusal of splints. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

12/8/2023

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L 065	Continued From page 20 the residents, and by encouraging and honoring resident's choices; (e) Assisting residents to adjust to their condition and to their use of prosthetic devices; (f) Achieving good body alignment and balance for residents who use mechanical supports, which are properly designed and applied under the supervision of a licensed nurse; (g) Identifying residents who would benefit from a bowel and bladder training program and initiating such a program to decrease incontinence and unnecessary use of catheters; and (h) Assessing the nature, causes and extent of behavioral disorientation difficulty and implementing appropriate strategies and practices to improve the same. This Statute is not met as evidenced by: Based on observations, record review, and staff interviews for one (1) of 47 sampled residents facility staff failed to ensure that each nursing employee assisted residents with adjustments to their conditions and use of prosthetic devices as part of the residents' daily restorative nursing care program. The findings included: Resident #25 was admitted to the facility on 08/21/08 with diagnoses that included: Unspecified Convulsions, Muscle Wasting and Atrophy, Schizophrenia, Muscle Weakness, Contracture Left Knee, and Dementia.	L 065		

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L 065	Continued From page 21 A review of Resident #25's medical record revealed the following: A Quarterly MDS dated 10/20/23 showed that facility staff coded the Resident as having a Brief Interview for Mental Status (BIMS) Summary Score of "06," indicating the Resident had severely impaired cognition, had functional limited range of motion to both upper and lower extremities, and was dependent on facility staff for all ADL (assisted daily living, such as grooming, bathing, transfers) care. A physician's order dated 12/04/19 read: "Carrot palms to prevent further tightness on at10:00 AM and off at 12:00 PM. A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has [a] risk for skin integrity impairment related to immobility, incontinence ...Goal: [Resident #25] will maintain the integrity of skin as evidenced by lack of redness or skin breakdown ... Interventions: Apply pressure relief cushions and devices per order." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has physical mobility impairment due to limitations to extremities and spasticity ...Goal: [Resident #25] will experience no complications of immobility (skin breakdown, contractures, atrophy, etc.) for the next 90 days (initiated 12/20/13) ...Interventions: ...splint application as recommended to right and left ext (extremity) ..." A care plan initiated on 12/19/19 documented, "Focus: [Resident #25] has a risk for complications related to contractures - Use of carrot palm guard to bilateral hands ...Goal: [Resident #25] will not have an increase of	L 065		

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L 065	Continued From page 22	L 065		

contracture by the next review in 90 days (initiated 06/14/16) ...Interventions: ...Apply carrot palm guards as ordered ..."

A physician's order dated 08/01/23 read: "Splinting order: Resident to wear bilateral palmer guard for 6 hours as tolerated to maintain skin integrity."

During an initial tour of the facility on 11/01/23 at 10:05 AM, Resident #25 was observed asleep, lying on her back in her bed. The resident's left hand was covered by the Resident's bed linen. The resident's right hand was visible and was contracted at the wrist. Lying on the bed, next to the resident's right hand was the right-hand palm guard. The left-hand palm guard was not observed on the resident's bed or in the resident's room.

During an observation on 11/03/23 at 1:40 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrists. No palm guard was applied to either hand.

During a face-to-face interview on 11/03/23 at 1:48 PM, Employee #23 (Restorative Nursing Aide/RNA), stated that she had not applied the resident's palm guards to the resident's hands, because the resident removed them all the time. When asked if she had let the Restorative Nurse Manager know that Resident #25 was not keeping the splints (palm guards) on, Employee #23 said that everyone knew including the Restorative Nurse Manager (Employee #22).

On 11/03/23 review of the Splint Monitoring Form for 11/01/23 to 11/03/23, showed that the Restorative Nursing Aides documented that they

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L 065	Continued From page 23 were applying Resident #25's splints at 7:00 AM and were removing the splints at 3:00 PM. During a face-to-face interview on 11/03/23 at 2:03 PM, Employee #22 (Restorative Nurse Manager), stated that the resident takes the palm guards off and throws them. When asked if she or any of the staff made the physician aware that the resident was removing the palm guards, she stated that she had not, but would do so. During an observation on 11/06/23 at 12:25 PM, Resident #25 was observed awake, lying on her back in her bed. The resident's left hand and right hand were contracted at her wrist. The resident's fingers on her right hand were tightly bent into her right palm. There were no palm guards applied to either hand. During a face-to-face interview on 11/06/23 at 12:20 PM, when asked about the Resident's palm guards, Employee #24 (Licensed Practical Nurse) observed that the Resident was not wearing the palm guards and stated that the RNA applied them earlier, but the Resident took them off. When asked if she had docuemneted the resident's behavior or had mentioned the resident's behavior to the physician, she stated that she had not. The employee then opened the top drawer of the resident's nightstand, removed the resident's palm guards, and started to apply them to the resident's hands. When Employee # attempted to straighten the resident's contracted fingers on her right hand, to apply the right-hand palm guard, the resident grimaced and stated that it hurt. The Employee then stated that she would mention to the physician the resident's refusal to keep the palm guards on her hands. Based on three observations, record reviews and	L 065		

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L 065	Continued From page 24 staff interviews, the evidence shows that the facility staff failed to provide appropriate treatment to increase Resident #25's range of motion or prevent the resident's further decrease in range of motion. In addition, facility staff failed to make the physician aware of the resident's refusal to wear her palm guards, so that alternative treatment for the resident's limited range of motion could be prescribed. [Cross-over tag F 688]	L 065		
L 099	3219.1 Nursing Facilities Food and drink shall be clean, wholesome, free from spoilage, safe for human consumption, and served in accordance with the requirements set forth in Title 23, Subtitle B, D. C. Municipal Regulations (DCMR), Chapter 24 through 40. This Statute is not met as evidenced by: Based on two (2) observations of the dishwashing cycle and staff interview, facility staff failed to ensure that the dishwasher reached the required temperature (150 degrees to 165 degrees Fahrenheit) to clean dishes and utensils under sanitary conditions. The findings included: During an observation in the facility kitchen on 10/31/23 at 10:55 AM, it was noted that the high temperature dishwasher, during the wash cycle, reached a high of 130 degrees Fahrenheit. In a second observation on 10/31/23 at 11:00 AM, the wash cycle temperature reached a high of 132 degrees Fahrenheit. During a face-to-face interview at the time of the	L 099	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcomes. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. Temperature logs were reviewed over the last 30 days to ensure that the wash cycle reached the proper temperature of 150-165 degrees Fahrenheit. The Maintenance Director has confirmed that as of 11/17, the dishwasher has been fixed in accordance with sanitary regulations. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided an in-service all dietary staff on the Policy and procedures regarding dishwasher temps. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION**	12/8/2023

			An audit will be done by the Administrator/designee to ensure the facility implements its policy on dishwasher temps in accordance with regulatory standards. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 099	Continued From page 25 both observations, Employee #25 (Food Service Director) acknowledged the findings and stated that the Maintenance Director would be notified to address the issue.	L 099		
L 128	3224.3 Nursing Facilities The supervising pharmacist shall do the following: (a) Review the drug regimen of each resident at least monthly and report any irregularities to the Medical Director, Administrator, and the Director of Nursing Services; (b) Submit a written report to the Administrator on the status of the pharmaceutical services and staff performances, at least quarterly; (c) Provide a minimum of two (2) in-service sessions per year to all nursing employees, including one (1) session that includes indications, contraindications and possible side effects of commonly used medications; (d) Establish a system of records of receipt and disposition of all controlled substances in sufficient detail to enable an accurate reconciliation; and (e) Determine that drug records are in order and that an account of all controlled substances is maintained and periodically reconciled. This Statute is not met as evidenced by: Based on one (1) of ten (10) observations, record reviews and staff interviews, facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed.	L 128	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcomes. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by all Unit Managers for all active residents on narcotics and a med pass was observed on each unit to ensure all procedures were followed. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided house wide in-service for licensed nurses on the Policy and procedures regarding narcotic reconciliation. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on narcotic reconciliation. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	12/8/2023

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L 128	Continued From page 26 The findings included: During an observation on 11/01/23 at 8:13 AM of the 3rd Floor narcotic book, it was noted that there was no signature in the section "Balance verified by nurse coming on duty" for the 7:00 AM - 3:00 PM shift on 11/01/23. The evidence showed that facility staff failed to ensure that the established procedures for the accurate reconciliation of narcotics were followed as evidenced by failing to sign off that the narcotic count was correct with the off-going nurse. During a face-to-face interview done at the time of the observation, Employee #19 (Licensed Practical Nurse/LPN) stated that her shift started 7:00 AM. The employee further stated, "I had to run to the bathroom during the [narcotic] count and forgot to sign off."	L 128		
L 168	3227.19 Nursing Facilities The facility shall label drugs, and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and their expiration date. This Statute is not met as evidenced by: Based on two (2) of ten (10) observations and staff interviews, facility staff failed to store and label biologicals in accordance with currently accepted professional practices. The findings included: According to the Institute for Safe Medication Practices (ISMP) - Vials of insulin dispensed from the pharmacy	L 168	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** No residents suffered any negative outcomes. The insulin pens were discarded on the day of the finding and new ones were ordered. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Unit Managers for all insulin stores on the medication carts and rooms. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice.	12/8/2023

			MEASURE TO PREVENT REOCURRENCE Nurse Educator/ Designee provided house wide in-service for Licensed Nursing staff on the Policy and procedures regarding storing and labeling biologicals in accordance with regulatory standards. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Unit Managers to ensure the facility implements its policy on biological labeling and storing in accordance with regulatory standards. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 168	Continued From page 27 should be labeled appropriately and include the patient's name. https://www.ismp.org/resources/clinical-reminder-about-safe-use-insulin-vials According to Healthline: - Insulin is effective for 28 days after opening - Users are supposed to mark the date they open a vial or began using a pen, and then keep track and discard it after 28 days https://www.healthline.com/diabetesmine/what-to-do-with-expired-insulin 1. During an observation of the 4th floor medication storage room on 10/31/23 at 2:10 PM, one opened Lantus (type of Insulin) vial stored for use that was not labeled with an open or expire date During a face-to-face interview at the time of the observation, Employee #21 (Licensed Practical Nurse/LPN), acknowledged the finding and appropriately discarded the Lantus vial. 2. During an observation of the 2nd floor, team 2 medication cart with Employee #20 (Licensed Practical Nurse/LPN) on 11/01/23 at 8:00 AM, one (1) Novolog (type of Insulin) pen stored for use that did not contain a resident label and one other Novolog pen that was not labeled with the date it was opened or the expire date. During a face-to-face interview at the time of the observation, Employee #20 acknowledged the findings and stated that she would discard the Novolog pens.	L 168		

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L 190	Continued From page 28	L 190		
L 190	3231.1 Nursing Facilities The facility Administrator or designee shall be responsible for implementing and maintaining the medical records. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff failed to ensure that the resident's medical records contained accurate information as evidenced by Resident #128's weekly skin assessments not accurately documenting the presence of multiple open areas that were documented elsewhere in the medical record. Resident #128 The findings included: A review of the facility's policy titled "Clinical Documentation Record" revised on 05/2023 documents " ...It is the policy of this facility to ensure accurate documentation of important elements contributing to high quality care of our residents ...Documentation Entries into organization documents or the health record (including but not limited to provider orders) must be: Accurate, valid, and complete ..." 2 The facility staff failed to accurately document the presence of open areas on Resident #128's weekly skin assessments. Resident #128 was admitted to the facility 09/20/23 with multiple diagnoses that included the following: Cutaneous Abscess of Right Lower Limb, Pressure Ulcer left Buttock Unstageable, and Pressure Ulcer of Unspecified Heal Stage 3. Review of Resident #128's medical record revealed the following:	L 190	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 229, 132, and 128 suffered no negative outcomes. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by ADON for all incidents and accidents and the Nurse Educator completed an audit for all skin assessments over the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. An audit was done on 12/6/23 by the ADON to check for refusal documentation when resident refuses to get out of bed. This deficiency cannot be retroactively corrected An audit was done on 12/6/23 by the Unit Managers to ensure the post fall huddle and weekly skin assessments contains accurate information. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding accurately documenting in the medical record. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Assistant Director of Nursing/designee for 10 residents per unit to ensure the facility implements its policy on accurately documenting in the medical record by	12/8/2023

			auditing documentation during resident transfers to the hospital, weekly skin assessments and post fall huddles. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 190	Continued From page 29 [Admission Note] 09/20/2023 at 2:22 AM documents " ..., has altered skin issues on unstageable Sacral decubitus ulcer measuring 11 x 13 cm (centimeters), Left hip DTI (Deep Tissue Injury) 9 x 10 cm, Right heel 9 x6 cm, R (Right)/foot 4 x 5 cm, R/knee eschar 5 x 3 cm, Left foot dorsal 2 x 4 cm, and double lumen Picc (peripherally inserted central catheter) line on right upper arm, ..." A review of the Admission Minimum Data Set (MDS) dated 09/25/23, revealed that the facility staff coded the following: Brief Interview for Mental Status BIMS score of "14" indicating intact cognition, the resident is at risk of developing pressure ulcers, the resident has one or more unhealed pressure ulcers, two (2) stage 3 pressure ulcers present on admission, one (1) stage 4 pressure ulcer present on admission, three (3) unstageable pressure ulcers present on admission and an infection of the foot. The facility staff coded that Resident #128 received the following skin and Ulcer/Injury treatments: Pressure reducing device for chair, turning /repositioning program, nutrition hydration intervention, pressure ulcer injury care, application of nonsurgical dressing, application of ointments/medications and application of dressing to feet. [Skilled Documentation] 10/17/23 at 10:22 PM, documents " ...Skin issues: osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection Active Infection" [Weekly Skin Assessment] 10/17/23, at 10:48 PM documents " ...Describe the skin impairment No new skin alteration" The interventions section was blank.	L 190		

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L 190	Continued From page 30 [Weekly Skin Assessment] 10/24/2023 at 9:06 AM, documents" ...Describe the skin impairment none.." The interventions section was blank. [Skilled Documentation] 10/25/23 at 2:02 PM, documents " ...Wound location(s) ...osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection." [Weekly Skin Assessment] 10/31/23 at 10:52 AM, documents " ...Describe the skin impairment none ..." The interventions section is left blank. [Skilled Documentation] 10/31/23 at 11:17 AM, documents "......Wound location(s) ...osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection." [Weekly Skin Assessment] 11/07/23 at 2:30 PM, documents "... Describe the skin impairment none ... " The interventions section is blank. [Skilled Documentation] 11/07/23 at 8:29 PM, documents "... Wound locations: Osteomyelitis, pressure ulcer left heel, sacrum, left ischium, rt foot infection ..." The weekly skin assessments from 10/17/23 through 11/07/23 inaccurately document the condition of Resident #128's skin. During a face-to-face interview conducted on 11/13/23 at approximately 12:00PM, With Employee #9 (Licensed Practical Nurse) stated they do skin assessments every week and she thought she was only to document if there were new wounds. During a face-to-face interview conducted on 11/13/23 at 10:20 AM, Employee #18 (Wound	L 190		

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L 190	Continued From page 31 Nurse) stated that the weekly skin assessments are inaccurate and acknowledged the findings.	L 190		
L 197	3231.8 Nursing Facilities Each facility shall maintain an area for processing medical records with adequate space, equipment, supplies, and lighting for staff. This Statute is not met as evidenced by: Based on record review and staff interviews for one (1) of 47 sampled residents, the facility staff failed to show documented evidence that the medical record served as a basis for planning resident care , by not providing a means of communication between the physician and the consultant pharmacist as evidenced by there being no evidence in the medical record that the physician reviewed the pharmacy regimen review for Resident #137. The Findings included: A review of the facility's policy tilted "Medication Regimen Review" with a revision date of 06/2023 documents " ...The Consultant Pharmacist shall review the medication regimen of each resident at least monthly ...Routine reviews will be done monthly ...Copies of drug/medication regimen review reports including physician responses will be maintained as part of the permanent medical record ..." Resident #137 was admitted to the facility on 11/14/22, with multiple diagnoses that included the following: Dementia, Paranoid Schizophrenia, and Gastrostomy Status. Review of Resident #137's medical record revealed the following:	L 197	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Resident 137 suffered no negative outcomes from failure to show documented evidence in the medical record that the Physician reviewed the Pharmacy Regimen Review. The completed Pharmacy review was uploaded in the resident's medical record on 12/8/2023. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Nurse Educator for all Pharmacy Regimen Reviews over the last 90 days to ensure they were documented in the medical record. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding the process to complete Pharmacy Regimen Review. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Assistant Director of Nursing to ensure the facility implements its policy Pharmacy Regimen	12/8/2023

			Reviews. This audit will be done for at least 5 residents per unit, weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 197	Continued From page 32 A review of a Quarterly Minimum Data Set (MDS) assessment dated 09/18/23, shows that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of 13 indicating intact cognition and as receiving antipsychotic medication. Pharmacy medication regimen reviews were reviewed in the medical record from 01/01/2023 to 10/02/2023. The pharmacist made recommendations on the following dates: 02/02/23, 03/01/23, 04/01/23, 04/28/23, 06/01/23, 09/01/23, and 10/02/23. The physician response to the medication regimen reviews were not present in Resident #137's medical record. During a face-to-face interview conducted on 11/06/23 at approximately 12:00 PM, Employee #10 (QA Quality Assurance) stated that the facility is in the process transitioning into 100% electronic health records and that the physician response to the pharmacist was in a binder in an office. Employee 10 acknowledged the findings.	L 197		
L 200	3231.11 Nursing Facilities Each entry into a medical record shall be legible, current, in black ink, dated and signed with full signature and discipline identification. This Statute is not met as evidenced by: Based on record review and staff interview, for two (2) of 47 sampled residents, facility staff failed to ensure resident's records contained accurate information. Residents' #174 and #132. The findings included:	L 200	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 379 and 174 suffered no negative outcomes from failure of MDS to accurately code the residents quarterly MDS assessment. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by MDS department for all residents that had a surgical wound and/or fall within the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice.	12/8/2023

			MEASURE TO PREVENT REOCURRENCE Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding how to accurately code residents for their MDS assessments. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on MDS assessments. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 200	Continued From page 33 1. Facility staff failed to accurately code Resident #174's An Admission MDS assessment. Resident #174 was admitted to the facility on 10/11/23 with diagnoses that included: Extradural and Subdural Abscess, Osteomyelitis of Vertebra, Lumbar Region and Urinary Tract Infection. Review of Resident #174's medical record showed the following: A Hospital Discharge Summary dated 10/11/23 at 2:45 PM documented that the resident had an L (lumbar) 4 - L5 laminectomy on 09/26/23. An Admission Note dared 10/11/23 at 9:12 PM documented: - Status post laminectomy and wound vac placement A Skin/Wound Note dated 10/12/23 at 3:43 PM documented: - Wound Nurse assessed patient - Right lower posterior back, 4 (length) x 3.7 (width) x 5.7 (depth) cm (centimeter) with the PSAOS abscess (collection of pus in the iliopsoas muscle compartment) - Wound vac in place A Physician's Progress Note dated 10/15/23 at 10:08 AM documented: - Status post laminectomy, wound vac placement PSOAS abscess An Admission /Medicare - 5 Day MDS assessment dated 10/16/2023 showed facility staff coded: a BIMS Summary Score of 15, indicating intact cognition and had no surgical wound(s).	L 200		

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L 200	Continued From page 34 The evidence showed that facility staff failed to Resident #174's Admission MDS assessment to capture that he had a surgical wound on his right lower back. During a face-to-face interview on 11/06/23 at 2:39 PM, Employee #15 (MDS Coordinator), reviewed Resident #174's Admission MDS assessment, acknowledged the finding and stated, "The MDS will have to be modified to capture the surgical wound." 2. Facility staff failed to accurately document Resident b#132's refusal of care in the Treatment Administration Record (TAR). Resident #132 was admitted to the facility on 07/23/22 with diagnoses that included: Muscle Weakness and Cognitive Communication Deficit. Review of Resident #132's medical record revealed the following: A physician's order dated 02/21/23 directed, "Continue use of brace when sitting up or out of bed, every shift" A physician's order dated 05/23/23 directed, "Resident needs to get out of bed to recliner daily, every day and evening shift" A Quarterly Minimum Data Set (MDS) assessment dated 07/30/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) summary score of 14, indicating intact cognition. A Complaint, DC12341, received by the State Agency on 10/04/23 documented: - [Resident #132] has been recommended by a	L 200		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
L 200	Continued From page 35 chiropractor to wear her back brace. This recommendation request the use of the back brace when she's sitting in a chair. I have witnessed back brace not being used as directed A care plan focus area: [Resident #132] is noncompliant with getting out of bed to the jerry chair, back brace was initiated on 10/11/23. During an initial observation of Resident #132 on 10/30/23 at 10:50 AM, she was observed lying in bed in bed. While the surveyor was in the room, the resident's assigned Certified Nurse Aide (CNA), Employee #26 entered the room and told the resident that she would be getting ready to put on her back brace and then getting her up into the chair. Resident #132 refused, stating, "I'm not getting out of bed today." The CNA asked again with the resident still refusing. During a second observation of Resident #132, on 10/30/23 at 2:40 PM, the resident was noted in bed. During a face-to-face interview on 10/30/23 at 2:43 PM, Employee #26 stated, "Resident refused to get out of bed today, I tried multiple times. I let the nurse know. She gets a shower tomorrow and usually on those days she'll sit up in the chair." Review of the Treatment Administration Record (TAR) on 11/02/23 at approximately 11:30 AM showed that on 10/30/23, day shift (7:00 AM - 3:00 PM), facility staff documented a check mark and their initials to indicate that the following order was administered and or carried out, "Resident needs to get out of bed to recliner daily every day and evening shift".	L 200		

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	HFD02-0001	A. BUILDING: _____ B. WING _____	C 11/14/2023

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L 200	Continued From page 36 The evidence showed that facility staff failed to accurately document that Resident #132 refused to get out of bed care on the TAR on 10/30/23. During a face-to-face interview on 11/02/23 at 11:52 AM, Employee #2 (Director of Nursing/DON) acknowledged the findings and stated, "We don't document things that weren't done or didn't happen."	L 200		
L 203	3232.1 Nursing Facilities Each facility shall maintain and keep for three (3) years, from the date of the incident, summaries and analyses of unusual incidents within the facility or on the premises with regard to a resident, visitor or employee, including but not limited to accidents, injuries, drug errors, abuse, neglect and misappropriation of resident funds. This Statute is not met as evidenced by: Based on record review and staff interview for two (2) of 47 sampled residents, the facility staff failed to show documented evidence that investigations were conducted into the following incidents: Resident #331's report to a social worker of a verbal altercation with another resident, Resident #332's abuse allegation and unusual incident, (Resident #331, #332) The findings included: A review of the facility's policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating" with a revision date of 06/2023 instructs the	L 203	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** Residents 103, 331, and 332 suffered no negative outcomes from failure to suspend employee, pending investigation. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the ADON for all incidents and accidents that occurred in the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee will in-service all staff and leadership on the Policy and procedures regarding suspending staff, pending investigations. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, Falls, are discussed during the Risk meetings to ensure the facility	12/8/2023

			implements its policy on investigating incidents of alleged abuse and reporting of unusual incidents to the appropriate law enforcement entity in a timely manner. Negative findings, if any, will be corrected upon discovery.	

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L 203	Continued From page 37 facility staff to do the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported... If resident abuse, neglect, exploitation, misappropriation of resident property, unusual occurrences or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law." 1 facility staff failed to investigate Resident #331's report of a verbal altercation with another resident. Resident #331 was admitted to the facility 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit. A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..." A review of Resident #331's medical record revealed the following:	L 203		

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L 203	Continued From page 38 [Social Work Progress Note] 01/09/23 at 11:19 AM, documents " ...Writer received a call from residents sister ...because resident call her & (and) shared that she had some type of verbal altercation with another resident ..." [Nursing Progress Note] 01/09/23 1:57 PM, documents ": In-House transfer from room 115D to Room 115A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated ..." [Physician Orders] 01/09/23 " ...In-House transfer from room 115D to Room 115A for comfort and socialization ..." Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a resident-to-resident altercation that was documented in the social work progress note. During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated. 2A The facility staff failed to investigate an allegation of abuse concerning Resident #332. A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: " ...Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion,	L 203		

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L 203	Continued From page 39 bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time ...On 10/27/2022, resident called the Admission Director with the following concerns, "Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice" ..." Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia. A review of Resident #332's medical record revealed the following: A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental status Score of "01" indicating severe cognitive impairment. [Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents " ...Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware ..." The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of	L 203		

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L 203	Continued From page 40 Nursing) stated the facility does not have an investigation into this incident. During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated "I don't remember that kind of report to me." During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them. 2B The facility staff failed to investigate an unusual occurrence concerning resident #332. Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia. A review of Resident #332's medical record revealed the following: A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of "01" indicating severe cognitive impairment. [Nursing Progress Note] 10/12/22 at 2:18 PM, documents," ...At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) ...with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and	L 203		

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L 203	Continued From page 41 she replied "I'm trying to give my mom supplements, She is what I do even when she was in the hospital". On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced the same education provided by the writer. [Individual name] verbalized "I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her. The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22 in the nursing progress note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility does not have an investigation into this incident.	L 203		
L 206	3232.4 Nursing Facilities Each incident shall be documented in the resident's record and reported to the licensing	L 206	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. Residents 331 and 332 suffered	12/8/2023

			no negative outcomes from failure to report to the state agency. **DENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the ADON for all incidents and accidents that occurred in the last 90 days to ensure they are reported as per the regulatory guidelines. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided a house wide in-service for staff and leadership on the Policy and procedures regarding the reporting requirements to the state agency. This education was completed on 12/6/23. Incidents like Abuse, neglect, injury of unknown origin, Falls etc are discussed during the Risk meetings to ensure the facility implements its policy on investigating incidents of alleged abuse and reporting incidents as per Federal and District guidelines in a timely manner. Negative findings, if any, will be corrected upon discovery. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee to ensure the facility implements its policy on abuse investigations. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023.	

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L 206	Continued From page 42 agency within forty-eight (48) hours of occurrence, except that incidents and accidents that result in harm to a resident shall be reported to the licensing agency within eight (8) hours of occurrence. This Statute is not met as evidenced by: Based on record review and staff interviews for two (2) of 47 sampled residents, the facility staff failed to report allegations of abuse and an unusual incident to the State Agency within 48 hours. Resident #331 and #332. The findings included: A review of the facility's policy titled "Abuse, Neglect, Exploitation or Misappropriation-Reporting and investigating" with a revision date of 06/2023 instructs the facility staff to do the following: All reports of resident abuse, including injuries of unknown origin, neglect, exploitation, or theft/misappropriation of resident property, are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported... 1. If resident abuse, neglect, exploitation, misappropriation of resident property, unusual occurrences or injury of unknown source is suspected, the suspicion must be reported immediately to the Administrator and to other officials according to state law." 1. The facility staff failed to report an allegation of a verbal altercation involving resident #331 and another resident to the State Agency. Resident #331 was admitted to the facility	L 206		

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L 206	Continued From page 43 01/05/23, with multiple diagnoses including Cirrhosis of the Liver, Muscle Weakness and Cognitive Communication Deficit. A review of a complaint intake #DC00011545 submitted to the State Agency on 01/23/23 documented " ...There are several concerns: 1/20/2023 -5:30 AM [Resident #331] falls on her back in the bathroom. I contact the front desk ask them to get her checked out nothing was done. No call to family and no doctor checked her out. I picked her up at 7:30 that evening and took her to [Hospital Name] where she was admitted ...In summary the place is not clean, staff not attentive, not a safe environment. My sister falls and nothing happens, no calls, no doctors nothing. DC really needs to do an inspection ..." A review of Resident #331's medical record revealed the following: [Social Work Progress Note] 01/09/23 at 11:19 AM, documents " ...Writer received a call from residents' sister ...because resident call her & (and) shared that she had some type of verbal altercation with another resident ..." [Nursing Progress Note] 01/09/23 1:57 PM, documents ": In-House transfer from room 115D to Room 115A for comfort and socialization. Resident in stable condition. Family informed of the transfer. Skilled services in progress and well tolerated ..." [Physician Orders] 01/09/23 " ...In-House transfer from room 115D to Room 115A for comfort and socialization ..." Resident #331's medical record lacked documented evidence that the facility conducted an investigation of the allegation of a	L 206		

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L 206	Continued From page 44 resident-to-resident altercation that was documented in the social work progress note. During a face-to-face interview conducted on 11/09/23 at 2:40 PM, Employee #2 (Director of Nursing) stated that the administration was not informed of the allegation of a resident-to-resident altercation by the social worker and that this is one of the reasons why the social worker was terminated. 2A The facility staff failed to report an allegation of abuse concerning Resident #332. A review of a Facility Reported Incident #DC00011144 submitted to the State Agency on 11/02/22 revealed the following: " ...Resident was transferred hospital on 10/23/22 due to chronic UTI that advanced to E-coli, causing confusion, bizarre behavior and cognitive decline. Report received by Admission department that resident [Resident #332] was observed bruising and scratching at the ED (Emergency Department). Also the daughter [Daughters Name] stated that resident missing clothing. Resident admitted [Hospital Name] at this time ...On 10/27/2022, resident called the Admission Director with the following concerns, "Accused tall dark brown skin CNA (Certified Nurse Aide) of hitting her mother twice" ..." Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia. A review of Resident #332's medical record revealed the following:	L 206		

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L 206	Continued From page 45 A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental status (BIMS) summary score of "01" indicating severe cognitive impairment. [Speech Therapy Treatment Encounter Notes] 10/10/22 at 10:21 AM, documents " ...Of note, pt (patient) daughter phone slipped out of hand and hit pt (patient) on top right forehead, RN (registered nurse) [Employee #9] made aware ..." The medical record lacked documented evidence of an investigation into the incident described in the Speech Therapy Treatment Encounter Note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated that the facility did not report this to the State Agency. During a face-to-face interview conducted on 11/14/23 at 12:57 PM, Employee #9 (Licensed Practical Nurse) stated "I don't remember that kind of report to me." During a telephone interview conducted on 11/14/23 at 1:20 PM, Employee #7 (Nurse Practitioner) stated that no allegation of abuse was reported to them. 2B The facility staff failed to report an unusual occurrence concerning resident #332 to the State Agency.	L 206		

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L 206	Continued From page 46 Resident #332 was admitted to the facility on 09/23/22, with multiple diagnoses that included the following: Diabetes Mellitus Type 2 with Diabetic Chronic Kidney Disease, Dysphagia, Oropharyngeal Phase, and Vascular Dementia. A review of Resident #332's medical record revealed the following: A review of an Admission Minimum Data Set (MDS) assessment dated 09/29/22, revealed that the facility staff coded the resident as having a Brief Interview for Mental Status (BIMS) summary score of "01" indicating severe cognitive impairment. [Nursing Progress Note] 10/12/22 at 2:18 PM, documents," ...At exactly 1:58 pm, while the Writer was making rounds, She observed the R/P (Resident Representative) ...with some pills on her left hand trying to force the one on her right hand into the mouth of the Resident. Writer asked [Individuals Name] what she was trying to do and she replied "I'm trying to give my mom supplements, She is what I do even when she was in the hospital". On the food tray behind [Individual Name] were (1)a cigarette Lighter, (2) Prepared Syringe with coffee color substance [Individual name] claimed that to be her CBD-Cannabis Oil (3)a container with different colors of pills and (4)a cup of orange liquid. She Claimed all these to be Supplements The Writer told her that it is not the policy of the facility and educated [Individual name] to notify or consult with the clinical team and Md (sp) (MD-Medical Doctor) before given loved ones any pill or medication of any type from home. Writer brought notified the Administrator and DON (Director of Nursing). Both accompanied the Writer to the Resident's room, the Administrator re-enforced	L 206		

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L 206	Continued From page 47 the same education provided by the writer. [Individual name] verbalized "I understand what y'all are saying and will go by the policies of the facility for the good of my mother, however I will like to get the list of my Mother's Medications. The Extension to the medical Records Dept(Department) was provided for her. The medical record lacked documented evidence that the facility staff investigated the unusual occurrence that was documented on 10/12/22, in the nursing progress note. During a face-to-face interview conducted on 11/13/23 at 3:38 PM, Employee #2 (Director of Nursing) stated the facility did not report this to the State Agency.	L 206		
L 410	3256.1 Nursing Facilities Each facility shall provide housekeeping and maintenance services necessary to maintain the exterior and the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. This Statute is not met as evidenced by: Based on observations, record review and staff interviews, for two (2) of 47 sampled residents, facility staff failed to provide housekeeping and maintenance services necessary to maintain the interior of the facility in a safe, sanitary, orderly, comfortable and attractive manner. Residents' #132 and #113. The findings included: 1. A Complaint, DC~12341, received by the State Agency on 10/04/23 from Resident #132's representative documented that:	L 410	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** The Housekeeping Director had an EVS employee come into resident 132's room to clean the unsanitary areas. This was completed on 11/2. Resident 113's walls were fixed the day of the findings by the maintenance department. No other residents were affected by these issues. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by the Director of Housekeeping and Director of Maintenance for proper cleaning methods and areas as well as room observations pertaining to chipped paint and wall damage since 11/1/23. This	12/8/2023

			audit will be completed by 12/8/23. Any negative findings will be corrected upon discovery and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/Designee in-serviced all Housekeeping and maintenance staff and leadership on the policy and procedures for room cleanliness and physical damage. This education was completed on 12/6/2023. **MONITORING CORRECTIVE ACTION** An audit will be done by the Administrator/designee for at least 10 rooms per unit to ensure the facility implements its policy on room cleanliness and physical damage in resident rooms. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery. Compliance date of 12/8/2023	

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	HFD02-0001	A. BUILDING: _____ B. WING _____	C 11/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INSPIRE REHABILITATION AND HEALTH CENT	2131 O STREET NW WASHINGTON, DC 20037

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L 410	Continued From page 48 - Residents are in unsanitary living conditions - The facility failed to provide daily clean and safe living environment During an observation of Resident #1332's room, 515 bed A, on 10/30/23 at 10:50 AM, the air conditioning/heating unit was noted with thick layers of gray dust-like material. The resident's over-bed table was sticky to the touch, wet, and had with dark colored stains. During a face-to-face interview on 10/30/23 at 10:55 AM, Employee #6 (Director of Housekeeping and Laundry) acknowledged the findings, stated that cleaning the resident overhead tables and the grills of the air conditioning/heating unit is part of the housekeeping duties and would get someone from housekeeping to come to Resident #132's room. 2. A Complaint DC~12130 received by the State Agency on 07/26/23 from Resident #113's representative documented that: - The facility is unclean - I have to ask for the floor to be mopped During an observation on 10/30/23 at 11:28 AM of Resident #113's room, 510, upon entering the room, two large areas of chipping paint and a large whole were noted on the right wall. During a face-to-face interview on 10/30/23 at 12:01 PM Employee #12 (Director of Maintenance) acknowledged the findings and stated, "Our maintenance guy made written note of this on Thursday (10/26/23) during his daily rounds but it was never entered into the electronic system as a request for me to see. We'll take care of it now."	L 410		

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L 534	3270.1 Nursing Facilities A transfer or discharge of a resident from a nursing facility shall be done in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985, effective April 18, 1986 (D.C. Law 6-108; D.C. Official Code §§ 44-1003.01, et seq. (2005 Repl. & 2011 Supp.)). This Statute is not met as evidenced by: Based on record reviews and staff interviews, for two (2) of 47 sampled residents, facility staff failed to transfer the residents to the hospital in accordance with the Nursing Home and Community Residence Facility Residents' Protection Act of 1985 as evidenced by not providing the resident or the resident's representative written information that specified the state bed-hold policy, to include the number of bed hold days. Residents' #87 and #278. The findings included: 1. Resident #87 was admitted to the facility on 04/11/19 with diagnoses that included: Benign Prostatic Hyperplasia, Cerebellar Ataxia and Degenerative Diseases of Basal Ganglia. Review of Resident #87's medical record revealed the following: A Modified Quarterly Minimum Data Set (MDS) assessment dated 08/04/23 showed facility staff coded: a Brief Interview for Mental Status (BIMS) Summary Score of 15, indicating intact cognition. A physician's order on 08/30/23 directed, "Transfer patient to nearest ER (emergency room) for evaluation and treatment for worsening	L 534	**CORRECTIVE ACTION FOR THE AFFECTED RESIDENTS** This deficiency cannot be retroactively corrected. The facility had self-identified the deficient practice and submitted the 6-108. Residents 87 and 278 suffered no negative outcomes from failure to notify them of the facility's bed hold policy and notice of transfer. **IDENTIFICATION OF OTHERS WITH THE POTENTIAL TO BE AFFECTED** All residents have the potential to be affected by this deficient practice. An audit was done by Social Services for all residents that were transferred or discharged over the last 90 days. Audit was completed on 12/06/2023 and no other residents were affected by this deficient practice. **MEASURE TO PREVENT REOCURRENCE** Nurse Educator/ Designee provided a house wide education for nurses and social service department on the Policy and procedures regarding notice of transfer and bed hold policy. This education was completed on 12/6/23. **MONITORING CORRECTIVE ACTION** An audit will be done by the Social Worker/designee to ensure the facility implements its policy on transfers and the bed hold policy for the residents transferred to the hospital. This audit will be done weekly for four (4) weeks and monthly for two (2) months. Findings to be reported to the monthly QAPI for further recommendations. All negative findings will be corrected upon discovery.	12/8/2023

			Compliance date of 12/8/2023.	

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L 534	Continued From page 50 sacral stage 4 wound and possible infection." An Admission Note dated 09/13/23 at 11:45 PM documented that Resident #87 was re-admitted from [Hospital name] at 8:30 PM. Review of a Notice of Discharge, Transfer or Relocation Form showed: - Submitted on 09/06/23 at 5:52 PM - Resident #87s name - Proposed action - transfer - Transfer type - hospital - You are scheduled to be transferred on 08/31/23 The evidence showed that facility staff failed to must provide Resident #87 written notice which specifies the duration of the bed-hold policy upon transfer to the hospital on 08/30/23. During a face-to-face interview on 11/06/23 at 10:35 AM, Employee #16 (Social Worker) reviewed Resident #87's Notice of Discharge, Transfer or Relocation Form and stated, "It was an oversight. When we caught it the following week, it was submitted." 2. Resident #278 was admitted to the facility on 07/18/22 with diagnoses that included: Muscle Weakness, Adjustment Disorder with Disturbance of Conduct and Anemia. Review of Resident #278's medial record revealed the following: A face sheet that documented the resident's daughter as the primary contact. A Quarterly MDS assessment dated 10/22/22 showed that facility staff coded: BIMS Summary Score of 01, indicating severely impaired	L 534		

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L 534	Continued From page 51 cognitive function. A Situation Background Assessment Request dated 12/08/22 at 10:32 AM documented: - Situation: Observed with a bump size of a quarter left side of head - New orders: Transfer resident to the hospital for CT (computed tomography) Scan /evaluation and treatment A Facility Reported Incident (FRI), DC~11326 submitted to the State Agency on 12/08/22 at 12:03 PM documented: - Around 9:55 AM, assigned Certified Nursing Assistant (CNA) observed a bump on the left side of head the size of a quarter - Medical Doctor assessed the resident ad order given to transfer resident to the emergency department for CT scan and evaluation A Nurse's Note dated 12/08/22 at 11:03 PM documented, "Writer placed a follow up call to [Hospital name] on the status of the resident, spoke with ER nurse, stated resident is admitted." An Admission Note dated 12/13/22 at 9:36 PM documented that the resident was readmitted from the hospital on that day to room 505 B. Review of a "Notice of Discharge, Transfer and Relocation Form" in Resident #278's medical record showed that the form was completed by Employee #16 (Social Worker) and it documented: - Submitted on 12/23/22 at 6:34 AM - Resident #278's representatives name - Proposed action - transfer - Transfer type - hospital - You are scheduled to be transferred on 12/08/22.	L 534		

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L 534	Continued From page 52 The evidence showed that facility staff provided Resident #278's representative notice of transfer to the hospital on 12/23/22, 15 days after the resident was initially transferred to the hospital and 10 days after the resident had already been readmitted back to the facility. During a face-to-face interview on 11/03/23 at 1:27 PM, Employee #16 stated that Notice of Discharge, Transfer and Relocation are to be provided immediately to the resident or the representative in person or via email. When asked about Resident #278's Notice of Discharge, Transfer and Relocation Form, Employee #16 reviewed the document, acknowledged the findings and stated," I don't know why this one was delayed."	L 534		